1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02456

1. PLACE OF DEATH — a. COUNTY: Wicomico — MARYLAND — b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury — c. LENGTH OF STAY IN 1b: — d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Pen Gen. Hospital

2480

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Wicomico — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury — d. STREET ADDRESS: 107 Fook St — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: SARAH — Middle: CATHERINE — Last: BAILEY

4. DATE OF DEATH: Month: FEBRUARY — Day: 7th — Year: 19 61

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 12, 1870

9. AGE (In years last birthday): 90 yrs. — IF UNDER 1 YEAR: Months: 8 Days: 25 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work — 10b. KIND OF BUSINESS OR INDUSTRY: None — 11. BIRTHPLACE (State or foreign country): Powellville, Maryland — 12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Hillary Bailey — 14. MOTHER'S MAIDEN NAME: Mary Ellen Parsons

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No — 16. SOCIAL SECURITY NO.: — 17. INFORMANT (Address): Mrs. Nellie A. Kennerly (Sister) 400 Newton Terrace Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days

491 X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture Rt. Humerus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH. — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fall at home

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: Jan 30 1961 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☒ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home — 20f. (City or town): Salisbury — (County): Wicomico — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Dr. Earl L. Royer — Address (Street, city, town, or county): 407 Camden Ave. Salisbury, Md

DATE SIGNED: Feb. 9 /1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Feb. 10/1961 — 22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park — 22d. LOCATION (City, town, or country): Salisbury, Maryland (State):

23. FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: FEB 14 '61 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Hines

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2481

Reg. Dist. No. 02457

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rumbley
d. STREET ADDRESS: 19X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Harold — Last: Beauchamp

4. DATE OF DEATH: Month: February — Day: 20 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 18, 1889

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10b. KIND OF BUSINESS OR INDUSTRY: waterman

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Harold Beauchamp

14. MOTHER'S MAIDEN NAME: Jennie Ford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 217-01-0903

INFORMANT: Mrs. Hazel Beauchamp Address: Princess Anne, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonic Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO (b): Generalized Arteriosclerosis — Yrs.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-20, 1961, to 2-20, 1961, that I last saw the deceased alive on 2-20, 1961, and that death occurred at 10:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H. P. Briele, M.D. — ADDRESS (Street, City or town, State): Medical Center, Salisbury, Md. — DATE SIGNED: 2-20-61

PHYSICIAN'S NAME (Type): H. P. Briele

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 2-23-1961

22c. NAME OF CEMETERY OR CREMATORY: Fairmount Cemetery

22d. LOCATION (City, town, or county) (State): Fairmount, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Lewis R. Baker — ADDRESS: Princess Anne, Md.

24a. REC'D BY REGISTRAR DATE: FEB 24 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2482 Item 2 FilmG282 3-14-61 et

CERTIFICATE OF DEATH

Reg. Dist. No. 02458

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
d. STREET ADDRESS ? Evans Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital

3. NAME OF DECEASED (Type or print) First: William Middle: Last: Beckett

4. DATE OF DEATH Month: February Day: 26 Year: 1961

5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1906
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Wicomico Co
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Beckett
14. MOTHER'S MAIDEN NAME: Lillie Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-26-4660
INFORMANT: Earl Beckett Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 331X
DUE TO (b) Cerebro Vascular Accident
DUE TO (c) Meningitis (Viral) Multiple Cerebral Hemorrhages.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19___, that I last saw the deceased alive on _____, 19_____, and that death occurred at 12:58 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Carrie Hearn M.D. ADDRESS (Street, city or town, state) 226 N. Division St DATE SIGNED 2/27/61

PHYSICIAN'S NAME (Type) CARRIE HEARN Salisbury Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3-2-61
22c. NAME OF CEMETERY OR CREMATORY Parks Rd Cem
22d. LOCATION (City, town, or county) Parks Rd Md (State)

23. FUNERAL DIRECTOR'S SIGNATURE Booker McDaniel ADDRESS Salisbury Md
24a. REC'D BY REGISTRAR DATE MAR 7 '61
24b. REGISTRAR'S SIGNATURE Clifton S. Knuth

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2483

CERTIFICATE OF DEATH

(02454)

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 Wk.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 1013 Smith St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Mitchell — Last: Bennett

4. DATE OF DEATH: Month: 2 — Day: 17 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 29, 1888

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Sup

10b. KIND OF BUSINESS OR INDUSTRY: Education

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Issac Bennett

14. MOTHER'S MAIDEN NAME: Laura Cooper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 219-36-6530

17. INFORMANT: Mrs. J.M. Bennett, Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of colon — INTERVAL BETWEEN ONSET AND DEATH: 1 Yr
DUE TO (b): Generalyzed carcinomatosis — 6 mon
DUE TO (c):

153.8

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ■ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-10 1961 to 2-17 1961, that (I) (we) last saw the deceased alive on 2-17 1961, and that death occurred at 12:27 PM, from the causes and on the date stated above.

22a. SIGNATURE: H.H. Duke M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/20/1961

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d. LOCATION (City, town, or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: The Hill & Johnson Co. Salisbury, Maryland

25a. REC'D BY REGISTRAR DATE: FEB 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2484

02461 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
d. STREET ADDRESS: Route 2 (PARKERTOWN)
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First THOMAS Middle HENRY Last Cathell

4. DATE OF DEATH: Month February Day 16 Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 16, 1879
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: OWN FARM
11. BIRTHPLACE (State or foreign country): BERLIN, MD. RFD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN HENRY CATHELL
14. MOTHER'S MAIDEN NAME: MARY ELLEN DAVIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 215-36-1128
INFORMANT: MRS. T. H. CATHELL Address: BERLIN MD R.F.D 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Cerebral Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-12, 1961, to 2-16, 1961, that I last saw the deceased alive on 2-16, 1961, and that death occurred at 3:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gilmore M.D. ADDRESS (Street, city or town, state): Salisbury Md. DATE SIGNED: 2/16/61

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/19/61
22c. NAME OF CEMETERY OR CREMATORY: EVERGREEN
22d. LOCATION (City, town, or county): BERLIN (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Amos A. Burbage ADDRESS: Berlin Md
24a. REC'D BY REGISTRAR DATE: FEB 20 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2485 02462

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hebron
c. LENGTH OF STAY IN 1b: 40 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hebron
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: LOUIS — Middle: AUGUST — Last: CISSEL

4. DATE OF DEATH: Month: 2 — Day: 21 — Year: 19 61

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 19,1895
9. AGE (In years last birthday): 65 yrs
IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Antiques
10b. KIND OF BUSINESS OR INDUSTRY: Dealer
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ernest Cissel
14. MOTHER'S MAIDEN NAME: Mary Ziegler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Army (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-32-0696
17. INFORMANT: Mrs. L.A.Cissel, Same — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b): Rheumatic heart disease & Aortic insufficiency — 10 yrs +
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/1 19 58, to death, 19 ___, that (I) (we) last saw the deceased alive on 2/15 19 61, and that death occurred at 1 PM, from the causes and on the date stated above.

22a. SIGNATURE: Ernest M. Larmore M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 2-23-1961
22c. PHYSICIAN'S NAME (Type): Ernest Larmore
22d. ADDRESS: Delmar, Del.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/23/1961
23c. NAME OF CEMETERY OR CREMATORY: St. PhilipIs Cemetery
23d. LOCATION (City, town, or county) (State): Quantico, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hill & Johnson Co. Salisbury, Maryland
25a. REC'D BY REGISTRAR DATE: FEB 24 '61
25b. REGISTRAR'S SIGNATURE: Curtis S. Travers

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2486 — 12463

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen Gen Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Powellville
d. STREET ADDRESS: R.D.#(Pittsville)
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: DAVID — Middle: WILLIAM — Last: DENNIS

4. DATE OF DEATH: Month: FEB. — Day: 4th — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: July 6,1895
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Station Operator
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Powellville, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William K.Dennis
14. MOTHER'S MAIDEN NAME: Ella Adkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes, give war or dates of service): W.W.II
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs.Myrtle R.Dennis(Wife) — Address: Powellville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: Seven months
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Emphysema
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year: N/A 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State): N/A

21 I certify that (I) (this hospital) attended the deceased from 1-25 1961 to 2-4 1961 that (I) (we) last saw the deceased alive on 2-4 1961, and that death occurred at M. from the causes and on the date stated above.

22a SIGNATURE: Wilber R. Ellis Jr. M.D.
ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]
22b DATE SIGNED: Feb. 6 /1961
22c PHYSICIAN'S NAME (Type): Dr.Wilber R.Ellis Jr
22d. ADDRESS: Medical Center - Salisbury, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb.7,1961
23c NAME OF CEMETERY OR CREMATORY: St.Johns Cemetery
23d. LOCATION (City, town, or county) (State): Powellville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
25a. REC'D BY REGISTRAR DATE: FEB 8 '61
25b. REGISTRAR'S SIGNATURE: Clifford L. Keene

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2487

CERTIFICATE OF DEATH

Item-8, Film-G-202 3/8/61.aac.

0246

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Spring Hill Road

d. STREET ADDRESS: 1 Spring Hill Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANCIS Middle ANTHONY Last ESSIG

4. DATE OF DEATH: Month FEBRUARY Day 26th Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 30, 1883

9. AGE (In years last birthday): 77 yrs

IF UNDER 1 YEAR: Months Days

IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner & Operator-Equipment Store

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Westminster Maryland

12 CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: George Essig

14 MOTHER'S MAIDEN NAME: ~~XXXXXXX~~ Elizabeth Schneider

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Mable Cross Essig (Wife) Address: Spring Hill Road Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Malnutrition and anemia — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO (b): Cerebrovascular Accident (Embolic) 2 wks;

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Carcinoma of prostate, metastatic 2 yrs;

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER):

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): N/A

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year: N/A 19

20d. INJURY OCCURRED White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A

20f (City or town) (County) (State): N/A

21. I **certify** that (I) (this hospital) attended the deceased from Feb 56 to Feb 21, 1961, that (I) (we) last saw the deceased alive on 2/19 1961, and that death occurred at 12:55 P. M., from the causes and on the date stated above

22a SIGNATURE: Rufus S. Gardner jr M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: Feb 27 /1961

22c PHYSICIAN'S NAME (Type): Dr. Rufus S. Gardner Jr

22d ADDRESS: Pine Bluff Rd. Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Mar. 1/1961

23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

23d. LOCATION (City, town, or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

25a REC'D BY REGISTRAR DATE: FEB 28 '61

25b. REGISTRAR'S SIGNATURE: Cuthbert L. Kniss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ex... within 24 ho... er death. Page 4 may be retained by the ho...al or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2488 (246.)

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen Gen Hospital

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 316 Wood St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HOWARD Middle LEE Last EVANS

4. DATE OF DEATH: Month FEBRUARY Day 3rd Year 1961

5 SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb.15,1918

9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months 11 Days 18
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brick Layer(Mason)

10b KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Salisbury,Maryland

12 CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Lee S.Evans

14. MOTHER'S MAIDEN NAME: Helen Agnew

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): YES (If yes, give war or dates of service): II

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs.Evelyn B.Evans(Wife) Address 316 Wood St Salisbury, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO (b): Pneumonia
DUE TO (c): Coronary Occlusion & Heart Failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A

20c TIME OF INJURY Hour o. m. p. m. N/A Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A

20f. (City or town) (County) (State): N/A

21 I certify that (I) (this hospital) attended the deceased from Dec 12 1961 to 2-3 1961 that (I) (we) last saw the deceased alive on 2-03 1961 and that death occurred at 5.4 M, from the causes and on the date stated above.

22a. SIGNATURE: Wm B Smith M D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: Feb 6 /1961

22c. PHYSICIAN'S NAME (Type): Dr. William B.Smith

22d ADDRESS: Salisbury, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb.6,1961

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d. LOCATION (City, town, or county) (State): Salisbury,Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

25a. REC'D BY REGISTRAR DATE FEB 8 '61

25b. REGISTRAR'S SIGNATURE: Irvin S. Kness

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2489 0246

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 321 E.Locust St

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 321 E.Locust St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle ELMER Last FITZGERALD

4. DATE OF DEATH: Month FEBRUARY Day 2nd Year 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 22,1899

9. AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months 7 Days 10 — IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employee- Roofing Co. Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Quantico Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James Fitzgerald

14. MOTHER'S MAIDEN NAME: Alice Ingersoll

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs.Lillian Fitzgerald(Wife) Address: 321 E.Locust Street Salisbury,Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardiac emergency — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Coronary Thrombosis

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): N/A

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year: N/A 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A

20f. (City or town) (County) (State): N/A

21. I certify that (I) (this hospital) attended the deceased from Jan 22 19 61 to 2-2 19 61 that (I) (we) last saw the deceased alive on 2-2 19 61, and that death occurred at 2:15 P.M. from the causes and on the date stated above

22a. SIGNATURE: Wm B Smith M.D

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: Feb. 5 /1961

22c. PHYSICIAN'S NAME (Type): Dr.William Smith

22d. ADDRESS: Salisbury,Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb.5,1961

23c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery(Walston)R.D.# Salisbury,Md.

23d. LOCATION (City, town, or county) (State):

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

25a. REC'D BY REGISTRAR DATE: FEB 8 '61

25b. REGISTRAR'S SIGNATURE: Orlan L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ex... within 24 hours after death. Page 4 may be retained by the ho... or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) TSM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2490

CERTIFICATE OF DEATH

12467

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanticoke c. LENGTH OF STAY IN 1b 9 Mo-
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanticoke
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Anna Middle Lawn Last
4. DATE OF DEATH Month Feb. Day 24 Year 1961

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 6/7/1873
9. AGE (In years last birthday) 87 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Jesse Tapman
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Address Tedlicey, Nanticoke, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident. — INTERVAL BETWEEN ONSET AND DEATH 2 Weeks

DUE TO (b) Generalized Arteriosclerosis — 10 years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 17 FEBRUARY 61 to 25 FEBRUARY 61 that (I) (we) last saw the deceased alive on 25 FEBRUARY 61 and that death occurred at 12:10 P.M., from the causes and on the date stated above

22a SIGNATURE Richard H. Saunders M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED 2/27/61

22c PHYSICIAN'S NAME (Type) Richard H. Saunders
22d. ADDRESS Nanticoke Md.

23a BURIAL, CREMATION, REMOVAL (Specify) Burial
23b DATE THEREOF 2/28/61
23c NAME OF CEMETERY OR CREMATORY Oak Hall Cem.
23d. LOCATION (City, town, or county) (State) Oak Hall, Va

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Cullen & Davis, Pocomoke, Md.

25a REC'D BY REGISTRAR DATE MAR 1 '61
25b. REGISTRAR'S SIGNATURE Arthur S. Kenna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2491

CERTIFICATE OF DEATH

02468

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 205 E. Chestnut St

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 1209 Railroad Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First IDA Middle MARSHALL Last GORDY

4. DATE OF DEATH: Month FEBRUARY Day 23 Year 1961

5 SEX: Female
6. COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 12, 1868
9. AGE (In years last birthday): 92 yrs
IF UNDER 1 YEAR: Months 9 Days 11
IF UNDER 24 HRS: Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work at home
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Sussex Co. Delaware
12 CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Marshall Smith
14. MOTHER'S MAIDEN NAME: Laura Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16 SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Hannie Ruth Allen (Daughter) Address: 205 E. Chestnut St. Delmar, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO (b): coronary artery occlusion — 2 weeks
DUE TO (c): coronary arteriosclerosis — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis generalized - Bronchial Ca, neck.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. N/A 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A
20f (City or town) (County) (State): N/A

21 I certify that (I) (this hospital) attended the deceased from ____ 19 56 to Feb 23, 1961, that (I) (we) last saw the deceased alive on Feb 23 1961, and that death occurred at 2:10 A M., from the causes and on the date stated above.

22a SIGNATURE: L. V. Sohler M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: Feb. 24 /1961
22c PHYSICIAN'S NAME (Type): Dr. L. V. Sohler
22d ADDRESS: Delmar, Maryland

23a. BURIAL, CREMATION REMOVAL (Specify): Burial
23b DATE THEREOF: Feb. 26, 1961
23c NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City, town, or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
25a REC'D BY REGISTRAR DATE: FEB 27 '61
25b REGISTRAR'S SIGNATURE: Esther L. Truitt

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2492

CERTIFICATE OF DEATH

(02463)

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsela

c. LENGTH OF STAY IN 1b: 6 months

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharptown, Md.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pal Shore Nursing Home

d. STREET ADDRESS: Main St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lucy — Middle: Windsor — Last: Gravenor

4. DATE OF DEATH: Month: Feb — Day: 4 — Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 20, 1872

9. AGE (In years last birthday): 88 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: George C. Windsor

14. MOTHER'S MAIDEN NAME: Nancy Russell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Lester Windsor — Address: Camden Court, Salisbury Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Stroke — INTERVAL BETWEEN ONSET AND DEATH: 10 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arterio Sclerotic Heart — 5 years

DUE TO (c): Arterio Sclerosis - General — 15 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. / p. m — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 25 1961 to Feb 4 1961, that (I) (we) last saw the deceased alive on Jan 25 1961, and that death occurred at 5:05 M, from the causes and on the date stated above.

22a. SIGNATURE: H S Kuhlman M.D. — Feb 4 '61 — 22b. DATE SIGNED

ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS ☐

22c. PHYSICIAN'S NAME (Type): H. S. Kuhlman

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb 7, 1961

23c. NAME OF CEMETERY OR CREMATORY: Pirelets

23d. LOCATION (City, town, or county) (State): Sharptown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Smith Funeral Home Sharptown, Md.

25a. RECD BY REGISTRAR DATE: FEB 7 '61

25b. REGISTRAR'S SIGNATURE: Arthur J. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2493

CERTIFICATE OF DEATH

(12470)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 day.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: VINE ST 22X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: L — Last: Hammond

4. DATE OF DEATH: Month: February — Day: — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 5, 1889

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MEAT DEALER

10b. KIND OF BUSINESS OR INDUSTRY: OWN BUSINESS

11. BIRTHPLACE (State or foreign country): WHALEYSVILLE MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: J. FRANKLIN HAMMOND

14. MOTHER'S MAIDEN NAME: LOUISE TAYLOR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WORLD WAR

16. SOCIAL SECURITY NO.:

17. INFORMANT: MRS. J. L. HAMMOND, BERLIN MD — Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Rupture of Aneurysm Abdominal Aorta — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

451X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerosis of Aorta

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — o. m. p m — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 1 19 61 to Feb. 1 19 61, that (I) (we) last saw the deceased alive on Feb. 1 19 61 and that death occurred at 4:45 M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS ☐ — **22b.** DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — **23b.** DATE THEREOF: 2/4/61 — **23c.** NAME OF CEMETERY OR CREMATORY: BUCKINGHAM — **23d.** LOCATION (City, town, or county): BERLIN (State): MD

24. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage — ADDRESS: Berlin Md.

25a. REC'D BY REGISTRAR DATE: FEB 6 '61 — **25b.** REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2494

CERTIFICATE OF DEATH

Reg. Dist. No. 0247

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): POCOMOKE CITY
d. STREET ADDRESS: 105 FOURTH STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RAYMOND Middle F. Last HANCOCK

4. DATE OF DEATH: Month FEBRUARY Day 5 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: SEPT. 27 1880

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: FARMING

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ROBERT W. HANCOCK

14. MOTHER'S MAIDEN NAME: LAURA REDDEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): N/O
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: 227-20-4004A

INFORMANT Address: MILTON S. HANCOCK, POCOMOKE CITY, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Remainder

420.0

DUE TO (b): ____

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): ____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-31, 1961 to 2-5, 1961 that I last saw the deceased alive on 2-5, 1961, and that death occurred at 6:20 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. S. Ellis Jr. M.D. ADDRESS (Street, city or town, state): Salisbury, Md. DATE SIGNED: 2-6-61

PHYSICIAN'S NAME (Type): W. S. ELLIS JR.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 2-8-61

22c. NAME OF CEMETERY OR CREMATORY: GOODWILL METHODIST

22d. LOCATION (City, town, or county) (State): RURAL-POCOMOKE CITY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry H. Watson — ADDRESS: POCOMOKE CITY, MD.

24a. REC'D BY REGISTRAR DATE: FEB 10 '61

24b. REGISTRAR'S SIGNATURE: Cathryn S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2495 (0247)

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Delaware
b. COUNTY: Sussex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seaford
d. STREET ADDRESS: Pine St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Etta — Middle: Mae — Last: Hardesty

4. DATE OF DEATH: February 2 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: May 1st, 1890
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Duties
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Seaford Del
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William S. Burton
14. MOTHER'S MAIDEN NAME: Elizabeth Ann Russell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Richard B. Hardesty — Address: 507 Hickory Lane, Seaford Del

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Hepatic Insufficiency	2 days
DUE TO (b)	Bone Marrow Failure	2 days
DUE TO (c)	Hodgkins Disease	3 mos

201X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. / p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/11 1961, to 2/2 1961, that (I) (we) last saw the deceased alive on 2/2 1961, and that death occurred at 3 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Rufus S. Gardner Jr. M.D
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/2/61
22c. PHYSICIAN'S NAME (Type): Rufus S. GARDNER, JR.
22d. ADDRESS: Pinehluff Rd., Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb 4, 1961
23c. NAME OF CEMETERY OR CREMATORY: Odd Fellows
23d. LOCATION (City, town, or county) (State): Seaford Delaware

24. FUNERAL DIRECTOR'S SIGNATURE: Harry E. Darby
ADDRESS: 300 Sixth St. Seaford Del

25a. REC'D BY REGISTRAR DATE FEB 6 '61
25b. REGISTRAR'S SIGNATURE: Curtis S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2496

CERTIFICATE OF DEATH

02473

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen Gen Hospital

d. STREET ADDRESS: 301 Quincy St

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MASON Middle WRIGHT Last HILL SR.

4. DATE OF DEATH: Month FEBRUARY Day 20 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 1,1902

9. AGE (In years last birthday): 58 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Sussex Co.Delaware

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Henry Hill

14. MOTHER'S MAIDEN NAME: Mary Milbourne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Mary E. Hill (Wife) Address: 301 Quincy St Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Diabetes Mellitus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): N/A

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year: N/A 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A

20f. (City or town) (County) (State): N/A

21. **I certify** that (I) (this hospital) attended the deceased from 8/29/58 19__ to 2/20/61 19__, that (I) (we) last saw the deceased alive on 2/20/61 19__, and that death occurred at __ M, from the causes and on the date stated above.

22a. SIGNATURE: A C Mitchell Mc M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: Feb. 22 /1961

22c. PHYSICIAN'S NAME (Type): Dr.Andrew C.Mitchell

22d. ADDRESS: Maryland Ave. Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb.23,1961

23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

23d. LOCATION (City, town, or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

25a. REC'D BY REGISTRAR DATE: FEB 24 '61

25b. REGISTRAR'S SIGNATURE: Clifton S. Truitt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2497

CERTIFICATE OF DEATH

Reg. Dist. No. 02476

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke
d. STREET ADDRESS: R.F.D. 2 x 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Perlie — Middle: — Last: Jones

4. DATE OF DEATH: Month: February — Day: 8 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JAN. 18, 1886
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY: FARM
11. BIRTHPLACE (State or foreign country): N. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
INFORMANT: Dorothy Hardy — Address: Pocomoke, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident (Thrombosis) — INTERVAL BETWEEN ONSET AND DEATH: 18 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized arteriosclerosis — ?
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1, 1961, to February 8, 1961, that I last saw the deceased alive on February 7, 1961, and that death occurred at 9:35 A.M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state)
DATE SIGNED: Feb. 8 1961
ACTUAL SIGNATURE: Robert Wallace M.D.
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-10-61
22c. NAME OF CEMETERY OR CREMATORY: R. B. Wharton Memorial
22d. LOCATION (City, town, or county) (State): Berkley, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar Wharton — ADDRESS: New Church, Va.
24a. REC'D BY REGISTRAR DATE: FEB 14 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2498 0247

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Parsonsburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.D.# 1 (Wango)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Parsonsburg - Rural
d. STREET ADDRESS: R.D.# 1 (Wango)
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First LEAH Middle CATHERINE Last LAWS
4. DATE OF DEATH: Month FEBRUARY Day 11th Year 1961

5 SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 2, 1864
9 AGE (In years last birthday): 96 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home
10b. KIND OF BUSINESS OR INDUSTRY: None
11 BIRTHPLACE (State or foreign country): R.D.# Parsonsburg, Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: George W.Jarman
14. MOTHER'S MAIDEN NAME: Sarah Ann Brittingham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17 INFORMANT Address: Mrs. Margaret Walker (Daughter) Berlin, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Degenerative heart disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yr.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized arteriosclerosis
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year: N/A 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A
20f (City or town) (County) (State): N/A

21 I certify that (I) (this hospital) attended the deceased from 5/X 1960 to 2/II 1961 that (I) (we) last saw the deceased alive on 2/II 1961 and that death occurred at 10:30P M. from the causes and on the date stated above.

22a. SIGNATURE: Earl M Beardsley M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: Feb. 13 1961
22c PHYSICIAN'S NAME (Type): Dr. Earl M. Beardsley
22d. ADDRESS: Maryland Ave. Salisbury, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb. 14, 1961
23c. NAME OF CEMETERY OR CREMATORY: Laws Family Cemetery
23d LOCATION (City, town, or county) (State): R.D.# Parsonsburg, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY
ADDRESS: SALISBURY MARYLAND
25a. REC'D BY REGISTRAR DATE: FEB 14 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Price

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2499

CERTIFICATE OF DEATH

0247.

M

X

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 30 Yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 403 S. Div. St.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d STREET ADDRESS: 403 S. Div. St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle VIRGINIA Last LIVINGSTON

4. DATE OF DEATH: Month 2 Day 25 Year 1961

5 SEX: Female
6 COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8-18-1876
9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b KIND OF BUSINESS OR INDUSTRY: Own Home
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Josephus Chatham
14. MOTHER'S MAIDEN NAME: Drucilla Messick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ——
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Wm. S. Martin, Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days.
DUE TO
332 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Nov. ___, 1960 to 2/25, 1961, that (I) (we) last saw the deceased alive on 2/25 1961, and that death occurred at 6:05 PM, from the causes and on the date stated above

22a SIGNATURE: Fred R. Gramse M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2-27-1961
22c PHYSICIAN'S NAME (Type): Dr. Fred R. Gramse
22d. ADDRESS: South Division St., Salisbury, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-28-61
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d LOCATION (City, town, or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hill & Johnson Co. Salisbury, Maryland
25a. REC'D BY REGISTRAR DATE: FEB 28 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2500 **CERTIFICATE OF DEATH** 02477

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Md. b. COUNTY Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Rural

c. LENGTH OF STAY IN 1b 6 months

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pine Shade Nursing Home

d. STREET ADDRESS Main St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Zipha Ellis Middle Last Ford

4. DATE OF DEATH Month February Day 21 Year 1961

5. SEX F

6. COLOR OR RACE W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH June 6, 1874

9. AGE (In years last birthday) 86 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Thomas J. Ellis

14. MOTHER'S MAIDEN NAME Annie Birley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT Address Mrs. Lottie Whatley, Laurel, Delaware

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 1½ hrs.

DUE TO 502.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Chronic Bronchitis 1 year

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 3 1960, to Feb 24, 1961, that (I) (we) last saw the deceased alive on Feb 24 1961, and that death occurred at 7:30 P.M. from the causes and on the date stated above

22a. SIGNATURE H. S. Kuhlman M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) H. S. Kuhlman

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF 2-26-61

23c. NAME OF CEMETERY OR CREMATORY Salisbury

23d. LOCATION (City, town, or county) (State) Salisbury, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Smith Funeral Home Shorptown, Md. Md.

25a. REC'D BY REGISTRAR DATE FEB 28 '61

25b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2501 Reg. Dist. No. 02478

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 14 mOs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Spring Hill Sanatorium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY: Luzern
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dallas
d. STREET ADDRESS: Center Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charlotte Middle Warman Last Mac Veigh

4. DATE OF DEATH: Month Feb. Day 27 Year 1961

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 4, 1886
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Salida, Colorado
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Cy Warman
14. MOTHER'S MAIDEN NAME: Ida Hayes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mr. J.H. Mac Veigh Dallas, Penn.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO (b): Cerebral Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 19 61, to Feb 27, 1961, that I last saw the deceased alive on Feb. 26 1961, and that death occurred at 1 0 A M, from the causes and on the date stated above.
ACTUAL SIGNATURE: David J. Salsbury M.D. ADDRESS (Street, city or town, state): Salisbury Md. DATE SIGNED: Feb. 28, 1961
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 2-28-61
22c. NAME OF CEMETERY OR CREMATORY: Manokin Presbyterian
22d. LOCATION (City, town, or county) (State): Princess Anne, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Lewis R. Wilson ADDRESS: Princess Anne, Md.
24a. REC'D BY REGISTRAR DATE: MAR 2 '61
24b. REGISTRAR'S SIGNATURE: Clarence L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2502

CERTIFICATE OF DEATH

1247

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury, Md.
c. LENGTH OF STAY IN 1b: Since 2/23/61
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pine Bluff State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dames Quarter
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Walter — Middle: Franklin — Last: McDorman

4. DATE OF DEATH: Month: Feb. — Day: 27 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/29/1887

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lighthouse Keeper U.S. Coast Guard

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Coast Guard

11. BIRTHPLACE (State or foreign country): Dames Quarter, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William McDorman

14. MOTHER'S MAIDEN NAME: Lettie Parks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 220-32-1516

17. INFORMANT — Address: Records of Pine Bluff State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Emphysema — INTERVAL BETWEEN ONSET AND DEATH: Unknown

5 27.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Tuberculosis 502X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 23, 1961, to Feb. 27, 1961, that (I) (we) last saw the deceased alive on Feb. 25 1961, and that death occurred at 2:40 A.M., from the causes and on the date stated above

22a. SIGNATURE: E P Ritchings M D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: Feb. 27, 1961

22c. PHYSICIAN'S NAME (Type): E. P. Ritchings

22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 3-1-1961

23c. NAME OF CEMETERY OR CREMATORY: Chance Cemetery

23d. LOCATION (City, town, or county) (State): Chance, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Geo. White — ADDRESS: Princess Anne, Md.

25a. REC'D BY REGISTRAR — DATE: MAR 2 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2503

(12401)

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 9 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Spring Hill Private Sanatarium

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 12
d. STREET ADDRESS: N. Division St., 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CAROLINE Middle COOKE Last McKOY

4. DATE OF DEATH: Month 2 Day 24 Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 1, 1869

9. AGE (In years last birthday): 91 yrs
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Maj. Augustus Buckner Cooke

14. MOTHER'S MAIDEN NAME: Sarah A. (Maiden name unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO: None

17. INFORMANT: Mr. Thomas H, McKoy Jr. Address: 1500 Walnut St., Phila, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardiovascular renal disease — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs

DUE TO (b): 442 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour ___ a. m. / p. m. Month ___ Day ___ Year 19___

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____ 19 50 to 2-24 19 61, that (I) (we) last saw the deceased alive on 2-23 19 61, and that death occurred at 7:07 M, from the causes and on the date stated above.

22a. SIGNATURE: Philip A Insley M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 2-25-61

22c. PHYSICIAN'S NAME (Type): Dr. Philip A. Insley

22d. ADDRESS: 116 E Main St., Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial&Removal

23b. DATE THEREOF: 2-27-61

23c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery

23d. LOCATION (City, town, or county) (State): Norfolk, Va.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: The Hill & Johnson Co. Salisbury, Maryland

25a. REC'D BY REGISTRAR DATE: MAR 2 '61

25b. REGISTRAR'S SIGNATURE: Clifton L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2504

1246

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
TSM 9/59

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND	2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury — c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital	d. STREET ADDRESS: Route 2 Jersey Rd. — e. IS RESIDENCE ON A FARM? YES ☒ NO ☐
3 NAME OF DECEASED (Type or print): First Lillian Middle — Last Mitchell	4. DATE OF DEATH: Month February Day 2 Year 1961
5. SEX: F. — 6. COLOR OR RACE: Col. — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: December 18, 1894 — 9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Cornish	14. MOTHER'S MAIDEN NAME: Kizzie Hopkins
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Elizabeth Chandler Address Salisbury Md. Jersey Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral arteriosclerosis — 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from _____, 19__ to Jan 31, 1961, that (I) (we) last saw the deceased alive on Jan 31 1961, and that death occurred at 2 1/4 PM, from the causes and on the date stated above

22a SIGNATURE: Theodore Swartz M D	ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐	22b DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE THEREOF: 2/5/1961	23c NAME OF CEMETERY OR CREMATORY: Green Acres	23d LOCATION (City, town, or county): Salisbury	(State): Md.
24. FUNERAL DIRECTOR'S SIGNATURE: Clinton F. Stewart	ADDRESS: Salisbury Md	25a. REC'D BY REGISTRAR DATE: FEB 14 '61	25b REGISTRAR'S SIGNATURE: Arthur S. Krauss	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2505 12462

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 20 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 507 Park Ave.,

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 12
d. STREET ADDRESS: 507 Park Ave., 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS Middle HENRY Last MITCHELL ,Jr.

4. DATE OF DEATH: Month 2 Day 9 Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug.10,1896
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bricks Maker
10b. KIND OF BUSINESS OR INDUSTRY: Owner
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas H. Mitchell Sr.
14. MOTHER'S MAIDEN NAME: Sally Wimbrow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Thomas H. Mitchell,Jr. Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO
(c)

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1956, 19__ to 2-7, 19 61 that (I) (we) last saw the deceased alive on 2-7, 19 61, and that death occurred at 2:30 P.M. from the causes and on the date stated above

22a. SIGNATURE: Fred R Gramse M D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 2/9/61
22c. PHYSICIAN'S NAME (Type): Dr. Fred R. Gramse
22d. ADDRESS: S. Div. St . Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/11/61
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City, town, or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hill & Johnson Co. Salisbury, Maryland
25a. REC'D BY REGISTRAR DATE: FEB 14 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2506 — 02463

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3½ weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Spring Hill Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: High St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: A. — Last: Molloy

4. DATE OF DEATH: Month: Feb. — Day: 26, — Year: 1961

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/25/1889

9. AGE (In years last birthday): 71 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stock Broker retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Boston, Mass.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Molloy

14. MOTHER'S MAIDEN NAME: Catherine Herlihy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW 1

16. SOCIAL SECURITY NO: 065-05-0527

17. INFORMANT: Mrs. Dorothy D. Molloy — Address: High St. Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Cardio vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized arteriosclerosis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 1, 1961, to 2-26, 1961, that (I) (he) last saw the deceased alive on 2-15, 1961, and that death occurred at 11:45 PM, from the causes and on the date stated above

22a. SIGNATURE: Rudyard Insley M.D

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 2/27/61

22c. PHYSICIAN'S NAME (Type): R. I. P. A Insley

22d. ADDRESS: Salisbury Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/1/61

23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem.

23d. LOCATION (City, town, or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells — ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: MAR 2 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2507

CERTIFICATE OF DEATH

12404

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md.
b. COUNTY: Wicimico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mattie; Middle: ; Last: MORRIS

4. DATE OF DEATH: Month: February; Day: 1; Year: 1961

5. SEX: F

6. COLOR OR RACE: Col.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-16-08

9. AGE (In years last birthday): 52 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS: Hours: ; Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Wicimico co.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lenwood Mitchell

14. MOTHER'S MAIDEN NAME: Maude Weatherly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-16-7332

17. INFORMANT: Address: Hayman Morris Quantico, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Massive Cerebellar Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 12 hours.

331 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Atherosclerosis. — Unknown

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: a. m. / p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/15, 1960, to 2/1, 1961, that (I) (we) last saw the deceased alive on 2-1-1961, and that death occurred at 4 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Richard H Saunders M.D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/2/61

22c. PHYSICIAN'S NAME (Type): RICHARD H SAUNDERS

22d. ADDRESS: NANTICOKE. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 2-4-61

23c. NAME OF CEMETERY OR CREMATORY: Quantico cem,.

23d. LOCATION (City, town, or county) (State): Quanyico, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Booker M. West

ADDRESS: Salisbury Md.

25a. REC'D BY REGISTRAR DATE: FEB 9 '61

25b. REGISTRAR'S SIGNATURE: Clifton L. Furness

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2508

CERTIFICATE OF DEATH

Reg. Dist. No. 0245

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
1SM 9/58

1 PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b COUNTY: Somerset
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Fairmount
d. STREET ADDRESS: 19x-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: C — Last: MOWBRAY

4. DATE OF DEATH: Month: FEBRUARY — Day: 23 — Year: 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 3-16-1879

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Lee Mowbray
14. MOTHER'S MAIDEN NAME: Sarah Bowen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: Mrs. Ida Mowbray — Address: Upper Fairmount Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): G.I. HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 18hrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b): CARCINOMA - PROBABLY GASTRIC c
DUE TO (c): HEPATIC METASTASES

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-20-61 19___ to 2-23-61 19___, that I last saw the deceased alive on 2-23-61 19___, and that death occurred at 5:40 A. M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state)
DATE SIGNED
ACTUAL SIGNATURE: James M. Chase Jr. M.D.
PHYSICIAN'S NAME (Type): JAMES M. CHASE, JR.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-25-61
22c. NAME OF CEMETERY OR CREMATORY: Fairmount Cemetery
22d LOCATION (City, town, or county) (State): Upper Fairmount Md

23. FUNERAL DIRECTOR'S SIGNATURE: Lewis R Wilson
ADDRESS: Princess Anne Md
24a. REC'D BY REGISTRAR DATE: MAR 2 '61
24b. REGISTRAR'S SIGNATURE: Clothus S. Kinna

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2509 Item 4 Number 1 2-21-61 et

CERTIFICATE OF DEATH

0248a

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 10 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 720 S. Park Dr.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 720 S. Park Dr.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lela; Middle: Schuder; Last: Payne

4. DATE OF DEATH: Month: 2; Day: 17; Year: 1961

5 SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 28, 1890
9. AGE (In years last birthday): 70 71 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James A. Schuder
14. MOTHER'S MAIDEN NAME: Clara Strader

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. Lewis Payne, Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary Artery Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

DUE TO (b): Coronary Atherosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension; Rheumatoid Arthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Jan. 1957 to Feb 17, 1961, that (I) (we) last saw the deceased alive on Feb 16 1961, and that death occurred at 7:30 P.M. from the causes and on the date stated above.

22a SIGNATURE: [signature] M D
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/20/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town, or county) (State): Covington, Va.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: The Hill & Johnson Co. Salisbury, Maryland
25a REC'D BY REGISTRAR DATE: FEB 24 '61
25b REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2510

Reg. Dist. No. 12467

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 4 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Stockton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Raymond Middle J. Last PILCHARD

4. DATE OF DEATH: Month FEBRUARY Day 23 Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 10-1884

9. AGE (In years last birthday): 76/4/13 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Pocomoke City, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ira Pilchard

14. MOTHER'S MAIDEN NAME: Ria Aydelotte

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-34-6192

INFORMANT: Mrs. Walter Merritt Address: Drumbackville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Stricture of Esophagus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 1960, to Feb 23, 1961, that I last saw the deceased alive on Feb. 22, 1961, and that death occurred at 2:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hill, Jr. M.D. ADDRESS (Street, city or town, state): Price Bluff Road, Salisbury, Md DATE SIGNED: 2/23/61

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial 22b. DATE THEREOF: Feb 26/61 22c. NAME OF CEMETERY OR CREMATORY: Union Methodist Cemetery 22d. LOCATION (City, town, or county) (State): Drumbackville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Clay E. Timms ADDRESS: Snow Hill, Md

24a. REC'D BY REGISTRAR DATE: FEB 27 '61

24b. REGISTRAR'S SIGNATURE: Clifton S. Truitt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2511

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Hammond St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Richard Middle: Willoughby Last: Porter

4. DATE OF DEATH: Month: 2-24-61 Day: Year: 19

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/26/1957

9. AGE (In years last birthday): 3 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Richard N. Porter

14. MOTHER'S MAIDEN NAME: Betty Webster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Richard N. Porter Address: Salisbury Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fractured skull: crushed chest.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 15 min.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATE

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Child struck by car pulling out of driveway.

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year: 5:15 P.M. 2-24-61

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Yard.

20f. (City or town): Salisbury (County): Wicomico (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☐. Accident ☒. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3-2-61

Address (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/28/61

22c. NAME OF CEMETERY OR CREMATORY: East New Market

22d. LOCATION (City, town, or county): East New Market (State): Md.

23. FUNERAL DIRECTOR: Ruth S. Willoughby ADDRESS: East New Market

24a. REC'D BY REGISTRAR DATE: MAR 9 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2512

CERTIFICATE OF DEATH

02483

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 Weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DELAWARE
b. COUNTY: SUSSEX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DELMAR
d. STREET ADDRESS: 300 JEWEL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: WILLIAM Middle: ROBERT Last: Powell

4. DATE OF DEATH: Month: 2 Day: 4 Year: 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-28-1881

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DERRICK-ENGINEER

10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD

11. BIRTHPLACE (State or foreign country): DELAWARE

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES POWELL

14. MOTHER'S MAIDEN NAME: RACHEL NEEDLES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 716-01-9416

17. INFORMANT: Blanch Powell Address: Delmar Del

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Adenocarcinoma rectum — 15 yrs — Unknown

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pt had local resection Ca rectum under Brudenell 7 yrs ago

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19__, and that death occurred at ___ M, from the causes and on the date stated above

22a. SIGNATURE: William H Fisher Jr. M.D.

ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-7-61

23c. NAME OF CEMETERY OR ~~CREMATORY~~: Mt Olive

23d. LOCATION (City, town, or county) (State): Delmar Del

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: W.S. Mandl Co - Delmar, Del

25a. REC'D BY REGISTRAR DATE: FEB 7 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2513

CERTIFICATE OF DEATH

02483

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 289 Loblolly Lane

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 289 Loblolly Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SARAH Middle LOUISE Last SHEAFFER
4. DATE OF DEATH: Month FEBRUARY Day 11 Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 20,1904
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Crisfield, Maryland
12 CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Fredrick G.Elmore
14. MOTHER'S MAIDEN NAME: Caroline B.Colonna

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT Address: Mr.John S.Sheaffer(Husband) 289 Loblolly Lane - Salisbury, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized carcinoma
DUE TO (b): adenocarcinoma of Breast
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3 1/2 yr.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.: N/A 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A
20f (City or town) (County) (State): N/A

21 I certify that (I) (this hospital) attended the deceased from April 24, 1960 to February 11, 1961, that (I) (~~we~~) last saw the deceased alive on February 11, 1961, and that death occurred at 1:30 PM, from the causes and on the date stated above

22a SIGNATURE: Robert T. Adkins M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: Feb. 13 /1961
22c PHYSICIAN'S NAME (Type): Dr.Robert T.Adkins
22d. ADDRESS: Fruitland, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Feb.15,1961
23c NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d LOCATION (City, town, or county) (State): Salisbury, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
25a REC'D BY REGISTRAR DATE: FEB 17 '61
25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2514

CERTIFICATE OF DEATH

02490

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury, Maryland
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marion Station, Md.
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elwood; Middle: -; Last: Sheehe

4. DATE OF DEATH: Month: Feb.; Day: 26; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: March 20, 1891

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seaman

10b. KIND OF BUSINESS OR INDUSTRY: Merchant Marine

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Daniel E. Shehee

14. MOTHER'S MAIDEN NAME: Lucy Blizzard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Hayes Diggs, Box 701, Crisfield, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
DUE TO (b): 50-D Generalized Arteriosclerosis — 10 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Tertiary Lues (according to history)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.: ; Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State):

21. I certify that (I) (this hospital) attended the deceased from Feb. 21, 1961 to Feb. 26, 1961, that (I) (we) last saw the deceased alive on Feb. 26, 1961, and that death occured at 9:10 AM from the causes and on the date stated above.

22a. SIGNATURE: Lee L Lawry M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2-26-61

22c. PHYS CIAN'S NAME (Type): Lee Lawry, M.D.

22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 28, 1961

23c. NAME OF CEMETERY OR CREMATORY: Crisfield Cemetery

23d. LOCATION (City, town or county) (State): Crisfield, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Bradshaw + Sons, Crisfield, Md.

25a. REC'D BY REGISTRAR: MAR 3 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2515 0249

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN MARYLAND: 307 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Preston
d. STREET ADDRESS: none
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John; Middle: Wesley; Last: Smith

4. DATE OF DEATH: Month: February; Day: 8; Year: 1961

5. SEX: Male

6. COLOR OR RACE: Col.

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Aug. 22, 1880

9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (County & State, or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Geerge Barnes

14. MOTHER'S MAIDEN NAME: Mammie Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): no

16. SOCIAL SECURITY NO: 218-20-3533

17. INFORMANT Address: records Deers Head Hospt. Salisbury

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Tuberculous pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

DUE TO (b): Abscess of the liver (multiple) — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 7, 1960, to Feb. 8, 1961, that (I) (we) last saw the deceased alive on Feb 7, 1961, and that death occured at 1:50 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Lee L Lawry

22b. DATE SIGNED: 2/8/61

22c. PHYSICIAN'S NAME (Type): Lee L. Lawry, M. D.

M D — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22d. ADDRESS: Deer's Head Hospital; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 2/10/61

23c. NAME OF CEMETERY OR CREMATORY: Mt. Pleasant Cemetery

23d. LOCATION (City, town or county) (State): Preston, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: H. Harry Wheatley - Salisbury, Md.

ADDRESS

25a. REC'D BY REGISTRAR DATE: FEB 14 61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2516

CERTIFICATE OF DEATH

(1245)

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 905 Hanover St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1 905 Hanover St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROSA — Middle ELLEN — Last SMITH
4. DATE OF DEATH: Month FEBRUARY — Day 2nd — Year 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 16, 1870
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months 6 — Days 16
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Fruitland, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Benjamin Dixon
14. MOTHER'S MAIDEN NAME: Catherine Hayman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Grace E. Williams (Daughter) Address: 905 Hanover St. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiovascular renal disease
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

442X

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year: N/A 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A
20f. (City or town) (County) (State): N/A

21. I certify that (I) (this hospital) attended the deceased from [illegible] 19[illegible] to 2-2 19 61 that (I) (we) last saw the deceased alive on 1-27 19 61, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: Carlyle Insley M D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Feb. 6 /1961
22c. PHYSICIAN'S NAME (Type): Dr. Philip A. Insley
22d. ADDRESS: Main St. Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb. 4, 1961
23c. NAME OF CEMETERY OR CREMATORY: Shad Point Cemetery - R.D.# Salisbury
23d. LOCATION (City, town, or county) (State): Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
25a. REC'D BY REGISTRAR DATE: FEB 8 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1 2

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2517 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Ite. 2 Rev. 6-61 2-cv-61 e

02493

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pen.Gen.Hospital ~~John B. Parsons Home for Aged~~

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: ~~Wicomico~~ Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Salisbury~~ Crisfield
d. STREET ADDRESS: ~~Lemon Hill~~ ??
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET; Middle —; Last STERLING

4. DATE OF DEATH: Month FEBRUARY; Day 9th; Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 8, 1872

9. AGE (In years last birthday): 88 yrs. IF UNDER 1 YEAR: Months —; Days —. IF UNDER 24 HRS.: Hours —; Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Wilmington Delaware

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: L E.P.Dennis

14. MOTHER'S MAIDEN NAME: Rebecca Smith Benson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) No (If yes give wer or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT (Name, Address): Records: The John B.Parsons-Home for the Aged Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage, Spontaneous — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Arteriosclerosis, generalized — 1 year
DUE TO (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fractured Rt. Femoral Neck

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell to floor John K. Parsons Home

20c. TIME OF INJURY: Hour 7:40 a.m. (p.m.) Month, Day, Year 12-17 1960

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Salisbury (County) Wicomico (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☒ Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: Earl L. Royer, M.D.

EXAMINER'S NAME (Type): Dr.Earl L.Royer, 407 Camden Ave. Salisbury, Md

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: Feb. 10 /1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb.12/1961

22c. NAME OF CEMETERY OR CREMATORY: Crisfield Cemetery

22d. LOCATION (City, town, or country) Crisfield, Maryland (State)

23. FUNERAL DIRECTOR: HOLLOWAY & COMPANY

ADDRESS: SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: FEB 14 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delays is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2518 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0249

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn St.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wenona
d. STREET ADDRESS: 19x-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Zack — Middle: — Last: Tawes

4. DATE OF DEATH: Month, Day, Year: 2-3-61 19

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DEC.-7-1877

9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman

10b. KIND OF BUSINESS OR INDUSTRY: SEAFOOD

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CALVIN TAWES

14. MOTHER'S MAIDEN NAME: EMILY GIBSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: VIOLET LACURTS — Address: GLENN ST SALISBURY-MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arterio-sclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

ADDRESS (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 2-4-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-5-61

22c. NAME OF CEMETERY OR CREMATORY: St. Johns Cemetery

22d. LOCATION (City, town, or country) (State): Deal Island MD

23. FUNERAL DIRECTOR: L. G. Webster — ADDRESS: Princess Anne Md.

24a. REC'D BY REGISTRAR DATE: FEB 7 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2519 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02495

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Stockton
d. STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Helen — Middle: E. — Last: Tull

4. DATE OF DEATH: Month: 2-1-61 — Day — Year: 19

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-3-1899

9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Education

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel F. Tull

14. MOTHER'S MAIDEN NAME: Florence Tull

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes g.ve war or dates of service): No

16. SOCIAL SECURITY NO.: unk

17. INFORMANT: Miss Madeline A. Tull, Address: 316 Fairfax Ave. Norfolk, Va.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fractured base of skull: crushed chest. — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Two car collision at intersection Rt. 12 and 354

20c. TIME OF INJURY: Hour a.m.: 4 P.M. — Month, Day, Year: 2-1-61

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town): Snow Hill (County): Worcester (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 2-4-61

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

ADDRESS (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-5-61

22c. NAME OF CEMETERY: Porterville Methodist

22d. LOCATION (City, town, or country) (State): Stockton, Maryland

23. FUNERAL DIRECTOR: Henry A. Watson

ADDRESS: Pocomoke City, Md.

24a. REC'D BY REGISTRAR: DATE FEB 7 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 with the State Board of Health.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event (within 72 hours after death.

VS. A1SME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2520 0249

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 61 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Ocean City Rd.,

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Ocean City Rd.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DAVID — Middle JENKINS — Last WARD

4. DATE OF DEATH: Month 2 — Day 18 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept 17,1871

9. AGE (In years last birthday): 89 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Lumberman

10b. KIND OF BUSINESS OR INDUSTRY: Lumber

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm. F. Ward

14. MOTHER'S MAIDEN NAME: Sarah Wimbrow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: D.J. Ward , Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Artery Heart Disease
DUE TO (b): Coronary Atherosclerosis
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 1 year

4206.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Aneurysm of Thoracic Aorta

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a m p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 2/20 1961 to 2/18 1961, that (I) (we) last saw the deceased alive on 2/18 1961, and that death occurred at 1:10 A.M. from the causes and on the date stated above.

22a SIGNATURE: David J. Gilmore M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 2-20-1961

22c PHYSICIAN'S NAME (Type): David J. Gilmore

22d ADDRESS: Salisbury, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 2-21-1961

23c NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d LOCATION (City, town, or county) (State): Salisbury, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: The Hill & Johnson Co. Salisbury, Maryland

25a REC'D BY REGISTRAR — DATE: FEB 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kenna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2521

CERTIFICATE OF DEATH

Reg. Dist. No. 1244

1 PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deal Island
d STREET ADDRESS —
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First GEORGE Middle D. Last Webstee

4. DATE OF DEATH Month Feb. Day 7 Year 1961

5. SEX M

6. COLOR OR RACE W

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ (Check)

8. DATE OF BIRTH Dec. 4-1960

9. AGE (In years last birthday) 0 yrs

IF UNDER 1 YEAR Months 2 Days 3 IF UNDER 24 HRS Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child

10b. KIND OF BUSINESS OR INDUSTRY Child

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JABEZ WEBSTER

14 MOTHER'S MAIDEN NAME MARY B. HASHER

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

INFORMANT Jabez Webster Address Deal Island Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congenital Heart Disease
7 - 4 - 4
DUE TO (Subendocardial Fibroelastosis)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchiolitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1/29, 1961, to 2/7, 1961, that I last saw the deceased alive on 2/7, 1961, and that death occurred at 5:05 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Alfred C Fuller M.D

ADDRESS (Street, city or town, state) Medical Center Salisbury Maryland

DATE SIGNED 2/7/61

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b DATE THEREOF 2-9-61

22c. NAME OF CEMETERY ~~OR CREMATORY~~ St Johns

22d. LOCATION (City, town, or county) (State) Deal Island Md.

23. FUNERAL DIRECTOR'S SIGNATURE L Webster ADDRESS Deal Island Md

24a. REC'D BY REGISTRAR DATE FEB 10 '61

24b. REGISTRAR'S SIGNATURE C. Lun S. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15-(4) 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2522 — 02495

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 210 W. Main St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ETHEL — Middle MAE — Last WHITE

4. DATE OF DEATH: Month 2 — Day 7 — Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-7-1885
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Clerk
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elihu W. White
14. MOTHER'S MAIDEN NAME: Annie Elizabeth Downing

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 214-10-7258
17. INFORMANT: Mrs. Jean Smith, Middle Blvd., Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebro-Renal Vascular Disease
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Jan 13 1961 to 2/7/61 19---, that (I) (we) last saw the deceased alive on Feb 7th 1961 and that death occurred at 6:20 P.M. from the causes and on the date stated above.

22a SIGNATURE: Carrie Hearn M.D
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 2-8-1961
22c. PHYSICIAN'S NAME (Type): Dr. Carrie I Hearn
22d. ADDRESS: 226 N. Division St., Salisbury, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 2-9-1961
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d LOCATION (City, town, or county) (State): Salisbury, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hill & Johnson Co. Salisbury, Maryland
Norman T. Baker
25a. REC'D BY REGISTRAR DATE FEB 10 '61
25b REGISTRAR'S SIGNATURE: Clifton L. Hearn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2523 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0249.3

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland
d. STREET ADDRESS: Box 157
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Pettes; Middle: Mathew; Last: White

4. DATE OF DEATH: Month: 2; Day: 17; Year: 61 19

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 29, 1933

9. AGE (In years last birthday): 27 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sailor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Corbin

14. MOTHER'S MAIDEN NAME: Jessie Corbin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Jessie Corbin Address: Fruitland Md Box 157

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fracture of Skull & cerebral
DUE TO (b): contusion severe
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell from truck while loading at sawmill.

20c. TIME OF INJURY: Hour a.m.: 11 A.M. Month, Day, Year: 2-14-61

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Sawmill

20f. (City or town): Fruitland (County): Wicomico (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐. Accident ☒. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.

DATE SIGNED: 2-20-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/22/1961

22c. NAME OF CEMETERY OR CREMATORY: Green acres

22d. LOCATION (City, town, or country): Salisbury (State): Md

23. FUNERAL DIRECTOR: Clinton F. Stewart ADDRESS: Salisbury Md

24a. REC'D BY REG.STRAR DATE: FEB 24 '61

24b. REGISTRAR'S SIGNATURE: Curtis L. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delays necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case not within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2524

CERTIFICATE OF DEATH

025.0

1. **PLACE OF DEATH**
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Deer's Head State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crisfield
d. STREET ADDRESS: Calvary Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

1939-2

3. **NAME OF DECEASED** (Type or print): First: Albert — Middle: James — Last: Whitman

4. **DATE OF DEATH**: Month: February — Day: 8 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 1, 1886

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ship Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Marine Railway

11. BIRTHPLACE (County & State, or foreign country): Northhampton County, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Whitman

14. MOTHER'S MAIDEN NAME: Virginia Parkinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-32-7956

17. INFORMANT — Address: Mrs. Ethel Whitman--Calvary Rd.--Crisfield, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Adeno carcinoma of Rectum — INTERVAL BETWEEN ONSET AND DEATH: 6 mon

154X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb. 2, 1961, to Feb. 8, 1961 that (I) (we) last saw the deceased alive on Feb. 7, 1961, and that death occured at 1:25 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Lee L Lawry M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2/8/61

22c. PHYSICIAN'S NAME (Type): Lee L. Lawry, M. D.

22d. ADDRESS: Deer's Head Hospital; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb.11,1961

23c. NAME OF CEMETERY OR CREMATORY: Crisfield Cemetery

23d. LOCATION (City, town or county) (State): Crisfield, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Robert H Bradshaw

ADDRESS: Bradshaw & Sons Crisfield, Md.

25a. REC'D BY REGISTRAR DATE: FEB 14 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/6D

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2525

CERTIFICATE OF DEATH

02501

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen Gen Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Salisbury (Rural)
d. STREET ADDRESS: R.D.# 3 (Walston)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First KING — Middle WILLIAM — Last WORKMAN

4. DATE OF DEATH: Month FEBRUARY — Day 18 — Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 24, 1883
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months 1 — Days 24
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Merchant
10b. KIND OF BUSINESS OR INDUSTRY: Grocery
11. BIRTHPLACE (State or foreign country): Worcester Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James Workman
14. MOTHER'S MAIDEN NAME: Elizabeth Hammond

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unk
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Martha A. Workman (Wife) Address: R.D.# 3 (Walston) Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchio-pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 wks
DUE TO (b): Arterio-sclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year: N/A 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A
20f. (City or town) (County) (State): N/A

21. I certify that (I) (this hospital) attended the deceased from Nov 19 20 to 2/18/61 19, that (I) (we) last saw the deceased alive on 2/18/61 19, and that death occurred at 2:35 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Fred R. Gramse M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Feb. /1961
22c. PHYSICIAN'S NAME (Type): Dr. Fred R. Gramse
22d. ADDRESS: S. Division St. Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb. 21, 1961
23c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery (Walston) R.D.# Salisbury, Md.
23d. LOCATION (City, town, or county) (State):

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
25a. REC'D BY REGISTRAR DATE: FEB 21 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59